

Financial incentives to improve adherence to antipsychotic maintenance medication

Poor adherence to maintenance medication is one of the major problems in the treatment of patients diagnosed with psychotic disorders, associated with exacerbation of symptoms, relapse and hospitalization. Providing financial incentives to motivate patients to adhere to their treatment has been previously found effective in a range of medical, and some mental health, conditions. However, whether or not financial incentives can improve adherence to anti-psychotic medication in patients with psychotic disorders has not been previously adequately assessed. Therefore, the aim of FIAT, a NIHR-funded multi-centre randomised controlled trial, was to examine the effectiveness and cost-effectiveness of financial incentives to improve adherence to anti-psychotic maintenance medication in patients with severe mental illness. The intervention period of the trial lasted for 12 months.

Participants with adherence to prescribed depot medication lower than 75% (the initial inclusion criterion was adherence as low as 50%, but this proved to be very rare) were recruited from community mental health teams and assertive outreach teams in England and Wales. Teams were randomly allocated to either the intervention condition in which participating patients received financial incentives of £15 for each depot medication taken, or the control condition in which patients continued with treatment as usual and did not receive anything. The majority of patients in both conditions received depot medication twice a month. The sum of £15 was carefully chosen not to create financial dependency, or interfere with patients' entitlement to benefits (which the majority of patients were on). The type, frequency and dose of depot medication were unaffected by the intervention.

The main outcome of the trial was the adherence to depot medication. We found that providing financial incentives had a significant effect on adherence rates:



■ Is money for medicine a good idea?

family therapy, or psychoeducation, has shown so far.

The study also investigated whether improved adherence is associated with changes in clinical outcomes. The number of hospitalizations and untoward events were low in both groups limiting the power of the study to detect any differences. Clinicians' ratings of clinical improvement were higher in the intervention group, although the effect was not statistically significant. Importantly, patients in the intervention group rated their subjective quality of life significantly higher than patients in the control group. One explanation is that thanks to the improved

fiat financial incentives
for adherence
to treatment

whilst in the control group adherence remained roughly the same (baseline adherence 67%, adherence at the end of intervention 71%), in the intervention group the adherence increased from 69% to 85%, which is by more than half of the possible improvement. In addition, in the intervention group, 28% of patients achieved adherence higher than 95%, in comparison to only 5% of patients in the control condition. This is an effect greater than any other intervention aimed at adherence to treatment improvement, such as compliance therapy,

treatment, patients were able to cope with problems better. Alternatively, this could be an effect of the financial incentives themselves, where receiving extra money does make a difference to patients' lives. Lastly, financial incentives could have also positively impacted on patients' relationship to services, by making patients feel rewarded, and more confident.

These possible explanations will be further examined by directly asking patients, as well as clinicians, about their opinions and experiences with the financial incentives in the follow-up stage, which is currently underway. During this last stage of the trial, we will also examine whether and how adherence and other outcomes changed after the financial incentives had stopped.



Can dialectical behaviour therapy keep people out of hospital – and what happens when the treatment stops?

By [Dr Kirsten Barnicot](#),
Unit for Social and Community Psychiatry

Last year in the R&D newsletter we reported the results of the DIALECT randomised controlled trial of dialectical behaviour therapy (DBT) versus treatment as usual (TAU) for people with personality disorder who self-harm. This study took place in the Newham DBT service, which offers a 12 month course of dialectical behaviour therapy including an hour a week of individual therapy and two hours a week of group skills training. This was compared to “treatment as usual”, which usually consisted of management by a community mental health team or outpatient psychiatrist clinic. We reported then that people randomly allocated to receive DBT were able to reduce or stop self-harming substantially more than people randomly allocated to receive TAU. However, that report left two important questions unanswered.

Firstly, severe incidences of self-harm, especially suicide attempts, can often result in people going to A&E, and from there, spending a while in hospital. It is well-known that people with borderline personality disorder, especially those who frequently self-harm, are particularly likely to be hospitalised. In fact, their use of A&E and inpatient psychiatric resources can be greater than that of people with other personality disorders and greater than people with major depressive disorder (Bender et al. 2001, Horz et al. 2010). This pattern of frequent hospitalisation is not only extremely disruptive and distressing for the people concerned, but also expensive for the NHS. Treatments which can reduce hospitalisation are therefore particularly needed in this patient group.

In the DIALECT study, 24 of the 80 participants had been hospitalised in the year before beginning treatment, with the number of inpatient days ranging from 0 to 365 (mean 20.5 days). The number of hospital days in the year before treatment was not significantly different between those allocated to DBT and those allocated to TAU. During the intervention year, only 2 of the 40 people allocated to DBT were hospitalised. This is shown in the graph below.

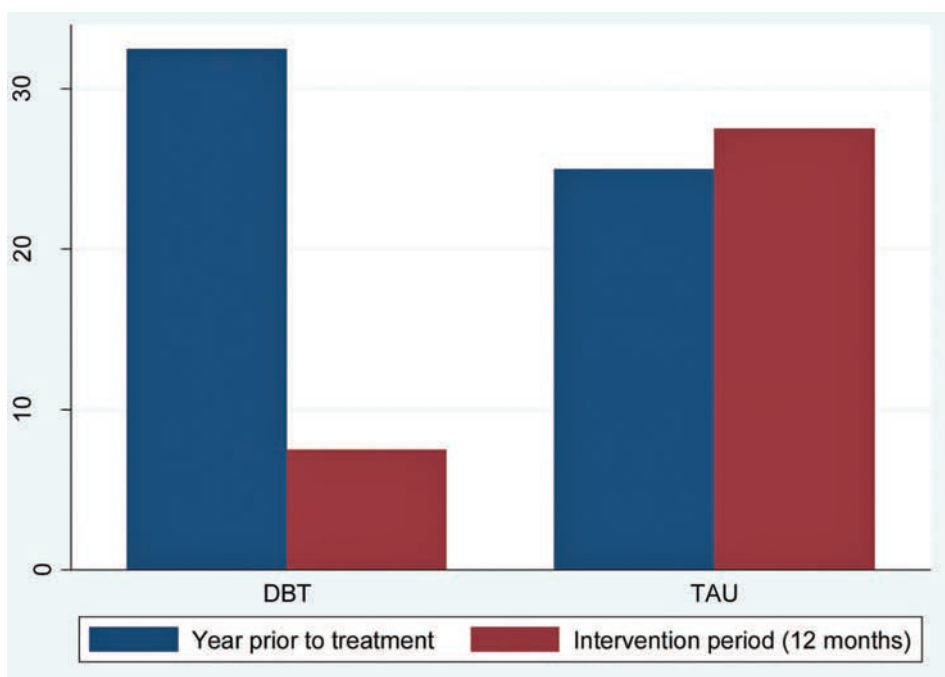


Figure 1: Percentage of patients hospitalised in each condition.

By contrast, 11 of the 40 people allocated to TAU were hospitalised. This was a statistically significant difference. This suggests that DBT is effective at keeping people out of hospital.

The second question it is important to address is what happens when the treatment stops. DBT is a very intensive treatment, with 3 hours of therapy a week. In addition, people are able to phone their therapists at any time for skills coaching if they are experiencing a crisis, albeit within certain hours set by the therapist. This level of support is rarely offered by NHS community mental health services, and once treatment ends, DBT participants will usually return to the much less intense support offered by outpatient psychiatric services. Furthermore, whilst ending therapy can be difficult and challenging for anyone, it is known to sometimes be particularly difficult for people with borderline personality disorder, evoking feelings of rejection and abandonment. Given the huge loss of

therapeutic support and the stress of losing the therapy relationship, a frequent worry is how people will cope once treatment ends and whether progress will be lost. With this in mind, we interviewed people who had completed the programme 6 months after the end of treatment to assess levels of self-harm and inpatient service use during that period. We found that, rather than worsening, self-harm had continued to decrease following treatment, and nobody who had completed the programme had any inpatient admissions.

The findings reported here indicate that DBT can be effective treatment for keeping people out of hospital, and that its benefits for reducing self-harm and reducing inpatient admissions are maintained even once the treatment finishes. However, we were not able to interview those who had dropped out of DBT without finishing the whole programme, and so it is not clear if any positive effects of treatment are maintained in this group also.

Upcoming Events

Research Training Sessions

The Academic Unit at the Newham Centre for Mental Health holds fortnightly training sessions on a variety of topics of interest to those undertaking research in the NHS. The training is held from 11:00-12:00 on a Wednesday in the Lecture Theatre; for more information, contact Husnara Khanom at husnara.khanom@eastlondon.nhs.uk

Date	Title	Presented by
4 December	<i>Systematic Reviews</i>	Erica Eassom
18 December	<i>Qualitative Interviewing</i>	Winnie Chow
Holiday intermission		
15 January	<i>Interpretative Phenomenological Analysis</i>	Mathew Colahan

Wanted: Research Study Participants

Professor of Clinical Psychology, Til Wykes was instrumental in establishing the Mental Health Research Network (MHRN) now part of the National Institute for Health Research (NIHR). The MHRN is supporting approximately 60 NHS trusts with mental health research. The MHRN has a team of Clinical Studies Officers (CSO) embedded within the NHS trusts to support research by, identifying and recruiting suitable

patient's and negotiating with NHS trusts on the study teams behalf. The MHRN helps studies to recruit to time and target.

From next April, the MHRN along with all other topic-specific research networks (e.g., Cancer Research, Primary Care, Dementia, etc.) will be combined into a single regional organisation to be known as the Clinical Research Network (CRN): North Thames. The brand is

changing, but the support to mental health research will remain. In East London Tara Harvey is the CSO supporting mental health research.

The following studies are actively recruiting in East London.; please feel free to contact Tara (07872 850 393 or tara.harvey@nhs.net) about any research projects mentioned below and please refer any potentially suitable candidates for the studies.

Molecular genetics of Adverse Drug Reactions to Clozapine

Who

Chief Investigator: Professor Pirmohammed
Local Investigator: James Innes
Clinical Studies Officer: Tara Harvey

What

This research project is looking to study the adverse drug reactions (ADR's). We are particularly interested in the adverse drug reactions of Clozapine, specifically Neutropenia and Agranulocytosis. This involves collecting DNA from cases with the aim of identifying genetic factors predictive of development of ADR's and hence allowing the possibility of prevention.

Where

Currently working with Clozapine clinics in Tower Hamlets and Newham and soon to be recruiting in City and Hackney.

Identifying the prevalence of antibodies to neuronal targets in first episode psychosis

Who

Chief Investigator: Dr Belinda Lennox
Local Investigator: Dr Savitha Eranti
Clinical Studies Officer: Tara Harvey

What

This study aims to understand if some cases of psychosis are caused by immune system problems in some individual's. The study is requiring patient's with first episode psychosis with less than 6 weeks on antipsychotic medication. Therefore patient referrals are much appreciated as there is a short time frame to catch these patients in.

Where

Currently working with Newham Early Intervention Service (EIS), but hoping to also recruit patients from EIS services in Tower Hamlets and City and Hackney.

Other Studies recruiting within the trust being supported by the MHRN

■ DNA variation in adults with learning disabilities (LD DNA) – Learning Disability service in City and Hackney

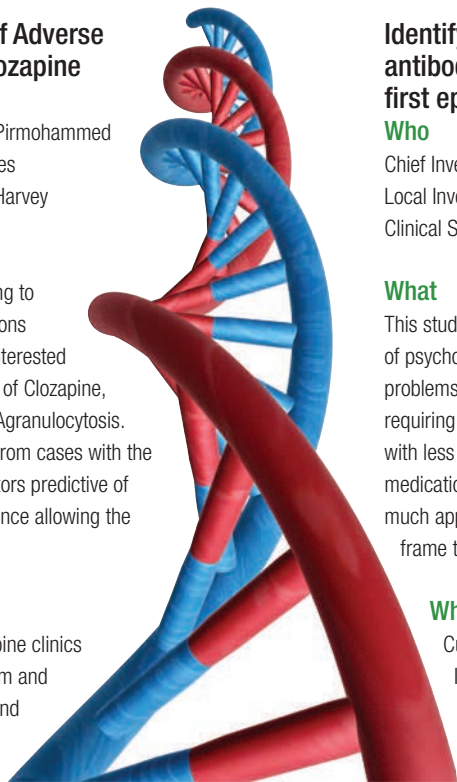
■ Positive behaviour Support (PBS) – Learning disability service in City and Hackney and Tower Hamlets

■ Self Harm Intervention: Family Therapy (SHIFT) – City and Hackney CAMHS

■ Communication approach on quality of life in secure mental Health settings (COMQUOL) – the John Howards Centre Forensic Unit

■ Collaborative Care Planning project (COCAPP) – Community Mental Health Teams in Tower Hamlets

■ Antipsychotic treatment of very late onset of Schizophrenia- like psychosis (ATLAS) – Newham, Tower Hamlets, and City and Hackney MHCOP.



Predicting future violence among individuals with psychopathy

The Trust's Forensic Psychiatry Research Unit, headed by Prof Jeremy W Coid, has identified the importance of making a diagnosis as the starting point for any structured risk assessment.

There are increasing expectations of public protection from violence and Forensic and general psychiatrists are required to carry out risk assessments. Healthcare and criminal justice professionals can be criticised if they make a wrong decision on release or detention of offenders, so the accuracy of the risk assessment instruments being relied upon most commonly is crucial.

Psychopathy is a rare personality disorder, but has a disproportionate impact on violence at a population level compared with other mental health disorders. With this in mind, Prof Coid and his team tested the predictive accuracy of HCR-20, VRAG & OGRS-II on predicting future violence among individuals with a high, medium or low PCL-R, where 30 or more indicates a psychopathic personality.

The accuracy of each instrument was moderate to good in individuals with no mental disorder, no more than moderate for those with a diagnosis of

schizophrenia, depression or substance use disorders and for those with antisocial and other personality disorders their predictive accuracy was poor or no better than chance. None of the instruments was better than chance when it came to predicting future violence amongst individuals with psychopathy. Prof Coid said "the tools available are no more accurate than tossing a coin when it comes to psychopaths."

Major implications

These findings have major implications for risk assessment; they indicate that these risk assessment instruments have limited use in environments with a high prevalence of severe personality disorders such as secure psychiatric hospitals and prisons. The study indicates that structured risk assessment instruments may be limited to measuring a general construct of criminal risk rather than specific tendencies to violence as originally intended.

The important message of this study is that general and forensic psychiatrists who are requested to carry out risk assessments for violence should be mindful of the limitations of some risk assessment

instruments when assessing those with psychopathy/psychopathic traits.

The research does not explain whether the failure of these instruments to predict violence is due to limitations in their construction, or the unpredictable behaviour of those individuals with psychopathy. One possibility is that the items included in the three instruments demonstrate little variation in psychopathic offenders. Alternatively, the ability of individuals with psychopathy to lie convincingly, con and manipulate even experienced clinicians may mean that accuracy can only be achieved with new actuarial tools excluding any items requiring subjective clinical judgement.

Whatever the reason for the instruments lack of accuracy in predicting future violence amongst the groups identified above, this research highlights an important need to prioritise the development of new assessment tools for these hard to predict groups. The most important future question is over risk management – i.e. what can be done to prevent further violent offending. This area needs to be prioritised for future research.

Do comorbid psychiatric disorders explain associations between adult attention-deficit/hyperactivity disorder (ADHD) and population violence?

By **Dr Rafael Alberto González**,
Post-doctoral Research Fellow,
Forensic Psychiatric Research Unit

ADHD is a mental health syndrome with onset in early childhood. In adulthood, the disorder is defined by hyperactive, impulsive and inattentive symptoms, difficulties with self-regulation and self-control, mood instability and general disorganization. It affects approximately 3–4% of UK children, and meta-analytic studies demonstrate that approximately 15% of cases continue to meet the diagnosis at 25 years of age, with a further 50% of individuals suffering impairment from persistent symptoms. It is one of the most prevalent mental health disorders in childhood and in adulthood and has a wide-ranging and detrimental impact on the wellbeing of individuals who usually suffer clinical and psychosocial problems.

One of the main difficulties from a public health perspective is that it is linked with high rates of comorbid psychiatric problems; ADHD is an established risk factor for additional psychiatric syndromes including substance misuse, mood and anxiety disorders and personality disorders. More recently, it has also been associated with violent criminality, including persisting offending, especially among sufferers of the disorder that have greater hyperactive or impulsive tendencies. Moreover, at least 2 recent studies propose pharmacological intervention to reduce violence in adult offenders with ADHD.

Violence is increasingly recognized as a major public health problem requiring intervention from healthcare professionals.

Because the potential impact on violence from neurodevelopmental psychopathology has not been systematically studied at the population level, Dr Rafael Gonzalez from the Trust's Forensic Psychiatry Research Unit conducted a study published in *PLoS*

One (Gonzalez et al. 2013, vol. 8, no 9) to determine the extent to which ADHD contributes to violence and the implications of further targeted interventions on ADHD to reduce violence. The study investigated: (1) the prevalence of self-reported violence associated with ADHD, its severity, victims and location of violent incidents and; (2) and whether the direct associations of ADHD with violence were explained by coexisting psychopathology, including mood and anxiety disorders, substance dependence and antisocial personality.

The study used data from the Adult Psychiatric Morbidity Survey (APMS, 2007), representative of the household population of England aged 16 and over living in private households. A randomly selected sample of 7,369 completed the Adult Self-Report Scale for ADHD and the self-reported violence module, including: repetition, injury, minor violence, victims and location of incidents.

Factors

Of 7,369 respondents, 8.4% reported any violence and the prevalence of ADHD was 5.7%. Socio-demographic factors of male gender, marital status other than married, and lower social class were significantly associated with violence risk.

Dr. Gonzalez found that ADHD was only modestly associated with violence in the population. Furthermore, the association was only for minor violent incidents where no one was injured and the police were not involved. After separating ADHD into two continuous measures of inattention and hyperactivity based on symptom dimensions, inattention demonstrated little or no impact on violence. However, hyperactivity was independently associated with violent incidents resulting in police involvement, with reports of victims in close relationships (i.e., domestic violence), and violence taking place in the perpetrator's home, as well as in pubs and bars. Hyperactivity, but not inattention,

was additionally associated with repetition of violent incidents.

The study also found a more complex relationship between increasing levels of severity of ADHD with any and repetitive violence. Unadjusted statistical models demonstrated a linear relationship with severity of ADHD. Following adjustments for coexisting psychopathology, moderate levels of severity still demonstrated associations with violence, but at the most severe level there were no direct associations. This suggests that the association with violence and its repetition among participants at the most severe level for ADHD was entirely explained by comorbid coexisting conditions, including ASPD, alcohol and drug dependence, and anxiety disorders, which were highly prevalent among participants in this severe group. The study concluded that violence towards others and its repetition is primarily related to coexisting psychopathology and not ADHD. However, because comorbidity is highly prevalent among those with ADHD, especially severe ADHD, violence should be highlighted as a key problem resulting in burden of care and high costs.

These findings have two important implications for targeted interventions to reduce violence for persons with ADHD. Firstly, medication treatment may be important if the aim is to reduce minor violence experienced by close persons, including intimate partners, family, and friends. But it is unlikely to reduce the risk of serious violence due to comorbid conditions. Nevertheless, the burden of care resulting from even minor violence directed towards close persons should not be underestimated. Secondly, psychological interventions with focus on the development of executive, regulatory techniques and coping skills may play a critical role in managing impulsive behaviour associated with ADHD and its common co-occurring disorders.

Upcoming Events

Winter Research Seminars in the Unit for Social & Community Psychiatry

The S&CP regularly holds seminars to present to work of its members. These seminars are free, open to the public and held from 14:00-15:00 in the Lecture Theatre, Academic Unit, Newham Centre for Mental Health. For more information, call Carolanne Ellis on 020 7540 4210.

Date	Title	Presented by
2 December	<i>Institutional care</i>	Winnie Chow
9 December	<i>VOLUME- Volunteering in Mental Health Care for People with Psychosis</i>	Paula Hermann
16 December	<i>Recruitment in the EPOS trial</i>	Husnara Khanom
Holiday intermission		
6 January	<i>Group music therapy for acute adult psychiatric inpatients</i>	Catherine Carr
13 January	<i>Carer involvement in the treatment of psychosis</i>	Erica Eassom
20 January	<i>Comparing functional and integrated systems of mental health care - a systematic review</i>	Serif Omer
27 January	<i>PROMO – Barriers to mental health care for long-term unemployed</i>	Aleksandra Matanov

Developing and refining nonverbal group therapies for specific clinical contexts

By **Catherine Carr**,
NIHR Clinical Doctoral Research
Fellow

In line with the Trust strategy to promote the use of nonverbal therapies in mental health care, a body of research is developing within the Unit for Social and Community Psychiatry with a current focus on group interventions of Body Oriented Psychotherapy and Music Therapy. Commonly known under the umbrella of 'arts therapies', which also include art, dance movement and drama therapy, these interventions focus upon the use of arts modalities to promote nonverbal forms of expression and communication. To date, our research has focused on evaluating the effectiveness of these interventions for specific diagnoses in randomised controlled trials and we have found positive effects for a range of mental health problems, particularly with patients who have long-standing problems that are difficult to treat.

Randomised controlled trials are invaluable when evaluating whether an intervention is really effective in addressing a particular problem, but they do not tell us how the intervention works, and the way the intervention is provided in the study can often differ dramatically from the reality of providing it in clinical practice. This is a particular challenge for psychotherapeutic group interventions, where a complicated range of processes and interactions are happening, often shaped not only by the individuals within therapy, but also by the context and environment they are offered.

Acute inpatient settings are one example of how the environment and context can impact upon the way an intervention is offered; reasons for and purposes of admission are varied, patients may be admitted involuntarily, and lengths of stay are increasingly short. Whilst evidence for music therapy in the treatment of serious mental disorders is growing and a number of models and methods for mental health care exist, little attention has been paid to how best to provide music therapy specifically to address acute inpatient needs.

An NIHR funded PhD study is looking into how best to provide group music therapy on acute inpatient wards. The first step in this PhD was a systematic review of international literature to



identify common features of how music therapy was provided, clinical aims and considerations and findings from studies conducted within these settings.

The review by Carr et al. published in *PlosOne* found that there is currently no single clearly defined model of music therapy in acute inpatient care. Practice varies widely, influenced by a wide range of models, methods and trainings. Despite this variation, features of setting-specific practice were identified, driven primarily by the short lengths of stay, patient diversity and institutional structure. Two features of music therapy which may be of particular importance in acute inpatient care are an increased frequency of therapy, and the use of active structured music making followed by verbal reflection. Building on this review, a study to develop a model of music therapy for acute inpatients is now exploring the role of these features and their impact upon patient experiences with findings expected in early 2014.

Complexity

The complexity of group psychotherapeutic interventions make it very difficult to assess whether a particular intervention is successful due to its unique, or 'specific' factors (for example, musical improvisation in music therapy), or due to factors shared with other interventions ('common' factors). One factor shared across many routine therapies in mental health care is the group format. There is a large body of research into the therapeutic mechanisms of group treatment yet the factors important to the group experience of patients are still poorly understood and rarely measured.

A study led by the University of

Ferrara, Italy, in collaboration with the Unit for Social and Community Psychiatry has led to the development of the Ferrara Group Experiences Scale (FE-GES). The FE-GES provides a means of assessing patient experiences of community mental health groups that is also brief enough to use in routine clinical evaluation. The scale, published in *BMC Psychiatry* by Caruso et al., assesses the extent to which patients felt they experienced helpful aspects of group relationships, sharing of emotions and experience, group learning and cognitive improvement. A unique feature of this scale is that it also assesses difficulties encountered by patients in expressing themselves openly. The scale was developed conceptually through consultations with patients and multi-disciplinary professionals, and piloted across a range of group modalities. Whilst the FE-GES still requires cross-validation with other countries, services and group treatments, it demonstrates good psychometric properties and may be used to evaluate not only the extent to which particular group factors are operating from the patient's perspective, but also to inform clinicians in their clinical decision making and practice of the group.

The FE-GES is now being used in both the music therapy study and a second PhD that is exploring the role of nonverbal group processes in clinical outcomes of patients with negative symptoms of schizophrenia. It is hoped that our research into these complex processes and interventions will enable us not only to better understand how and why nonverbal therapies are effective, but to also enable us to refine these interventions so that they are applicable, relevant and take into account the specific features of clinical contexts.

OTHER NEWS

NEW WEBSITE FOR HRA NOW LIVE

The new Health Research Authority (HRA) website is now live at www.hra.nhs.uk. It has been structured to guide researchers through the approvals process, and has been developed in conjunction with HRA staff, REC members, patients, researchers and R&D staff. The HRA are keen to hear your views on the new site, which can be provided through a short survey - <https://www.surveymonkey.com/s/VLF6LHC>

RDS LONDON SUCCESSFULLY AWARDED FURTHER FIVE YEARS FUNDING

Research Design Service (RDS) London has been awarded £5.6m from the National Institute for Health Research (NIHR) to continue hosting RDS London for a further five years. The award will continue to fund the cost of research advisers who provide practical support to researchers across London who are preparing grant applications.

Since its launch in 2009, the service has supported 167 successful funding applications with a total award value in excess of £65 million. RDS London will build on this success and develop the service so that it continues to meet the needs of research teams in the capital. Part of the new strategic plan is to increase outreach by expanding the highly successful Research Design Clinics. Webcasts and a new knowledge hub will be new additions to the RDS London website (www.rdslondon.co.uk), which will increase the accessibility of the service.

INVOLVE LAUNCHES invoDIRECT: A NEW ONLINE RESOURCE FOR PUBLIC INVOLVEMENT

invoDIRECT is a new online map on the INVOLVE website. The map displays information on groups and organisations that support public involvement in NHS, public health and social care research. Visit invoDIRECT at www.invo.org.uk/find-out-more/invodirect to search for local, national, and international groups and organisations supporting public involvement in research.

Services fail to treat prisoners with schizophrenia

The Trust's Forensic Psychiatry Research Unit, headed by Prof Coid, has published research (Keers et al, *Am J Psychiatry*) showing that released prisoners with schizophrenia are three times more likely to be violent than other prisoners, but only if they receive no treatment or follow-up support from mental health services.

The research team compared the occurrence of violence among prisoners with schizophrenia, delusional disorder, or drug-induced psychosis, who 1) did not receive treatment whilst in prison or upon release; 2) received treatment only during prison; or 3) received treatment during prison and after release. The same research was also carried out among prisoners with no psychosis as a baseline.

Prisoners with schizophrenia who remained untreated during and after imprisonment were three times more likely to be violent following release than those who received treatment. Results revealed that the cause of this violent behaviour was linked to new emergence or re-emergence of delusional beliefs, specifically that someone or something was out to harm them – a symptom caused by lack of treatment.

Despite psychosis being considered an important risk factor for violence, current risk assessment tools do not take account of treatment, so miss out what is emerging as a vital part of the puzzle. The results of this study indicate that the emergence of persecutory delusions in untreated schizophrenia explain violent behaviour, thereby indicating better screening and treatment of prisoners is essential to prevent violence.

The findings of this study are novel and require replication in independent samples. However, the findings are consistent with studies of treatment compliance in psychosis that report non-adherence to medication associated with increased risk of violence. This also reflects the opinion of most clinicians that on-going treatment reduces risk of future violence



amongst persons with schizophrenia. This also gives us clues as to why past investigations into relationship between violence and schizophrenia have been inconsistent. Treatment may be the key to elucidating what has up to now been a controversial topic.

Misconceptions

Many misconceptions remain in our society about what it means to have a psychotic disorder. Most people with schizophrenia are not violent. However, among those who have shown severe violent tendencies and have been imprisoned as a result, the risk of future violence is greatly increased if they are no longer treated after

they leave prison. For those who were not identified as suffering from mental illness, and who never received any treatment, the risks could be even higher, and this requires further study.

Despite the high prevalence of mental disorders among prisoners, treatment is often less available in prison than in the outside world. A recent study found that mental health teams successfully identified only 25% of prisoners with severe mental illnesses and only 13% were accepted onto their caseloads. It is estimated less than 25% of prisoners who screen positive for psychosis will subsequently receive an appointment with a mental health professional after release. Unfortunately, many prisoners will decide not to comply with follow-up after their release, but for those who were not identified

as suffering from schizophrenia and who did not receive treatment, the chances of them receiving treatment after release are slim.

It cannot be stressed enough that this is an important public health problem. At the moment the system is failing high-risk people with psychotic disorders and the public by not screening and treating people with severe mental disorders well enough, nor accurately evaluating risk when they are released from prison. Improved screening and initiating treatment whilst in prison, and then maintaining treatment and follow-up after release, are essential in violence prevention.

Getting Involved in Research and Innovation

A new role was therefore developed in order to specifically focus on research and innovation across the organisation, to support the implementation of research findings in clinical practice, to foster provision of evidence based services and innovation and to identify adequate and effective new initiatives for service development.

Research and Innovation has long been

perceived as only relevant for academic/university staff but it is a matter that should be taken forward by all staff, and in particular front line clinicians.

In my new role as Associate Medical Director for Research, Service Development and Innovation I am very keen to connect with all staff across all disciplines and I would be very grateful if you could complete this short questionnaire. If any

of the questions is answered with YES, please provide more details. I am VERY MUCH looking forward to hearing from you and sincerely hope you will spend a few minutes and send me your thoughts and ideas: frank.rohricht@eastlondon.nhs.uk

All responses will be put forward into a strategy document which I am going to share with staff at the end of the year.

Thank you very much!



■ Prof Frank Röhricht, Associate Medical Director for Research, Service Development and Innovation

- 1. Are you currently involved in research or innovation projects? Have you previously been involved in any research or innovation projects?
- 2. Do you have any skills and/or experiences that you could offer in terms of supporting research, service development and innovation?
- 3. Do you have an area of special interest? Would you be interested in joining a SI research group or a local think tank?
- 4. Can you think of 1-3 research questions that you regard as relevant for clinical practice?

- 5. What would help you to get involved with research and how do you think we can best translate research findings in to everyday practice?
- 6. If you could deliver / implement innovative practice in this Trust, what would it be?
- 7. If you would be given one half day a week free to choose your work, what would you do?
- 8. If you could change one thing tomorrow within ELFTs services / practices what would it be?

Comparing Integrated and Functional Systems of Mental Health Care in Europe: The COFI Project

By **Dr Domenico Guacco**,
Research Fellow, Honorary Senior Lecturer, Unit
for Social and Community Psychiatry

In February 2014, the Unit for Social and Community Psychiatry will begin coordinating the project “COMparing policy framework, structure, effectiveness and cost-effectiveness of Functional and Integrated systems of mental health care” (or COFI), a large scale study funded by the European Commission that will be carried out over four years in five countries including the United Kingdom. The aim of the study is to compare two alternative models of mental health care organization, i.e. integrated and functional systems.

Why was this project needed?

Mental disorders are a leading cause of disability throughout Europe resulting in high personal and societal burden. They cause significant health care costs and heavily affect work functioning and the quality of life of patients. This burden can be reduced by optimizing how services are organized leading to greater effectiveness of mental health care.

A number of attempts have been made to improve the organization of mental health services, often through radical reforms. These reforms are associated with far reaching changes for clinical practice and consume large amounts of funding. Yet, they have been mainly designed on the basis of experts' opinions. At present, the scientific evidence available in this field is scarce.

Mental health care reforms and the related debates have focused on one central and controversial issue: should mental health care systems be functional or integrated?

What are functional and integrated systems?

The two different types of systems can be summarized as:

1) **Functional systems:** care is provided by different teams in distinct services, and the transition between services is coordinated through a network of regulated referrals.

2) **Integrated systems:** care is provided and coordinated by the same mental health team across different services.

In functional systems, patients receive care from

different specialized mental health teams with each service providing a limited number of interventions, reflecting the general tendency in medicine towards specialization. Suggested advantages of functional systems are an improvement of clinical governance and the specialization of clinicians' skills. Given the increase in the evidence base for mental health interventions, it is seen as unrealistic for a professional to remain fully informed and competent to treat all psychiatric disorders; instead, in functional systems, professionals specialize in providing treatment for a limited number of disorders and/or for specific groups of patients. From the patients' point of view, functional systems could also allow them to have more choice about their treatment as they can select the services specially designed for their specific mental health needs.

In contrast, integrated systems are characterized by continuity and coordination of different interventions by the same mental health team. Integrated systems have been set up to avoid fragmentation of services, to ensure continuity of care and to facilitate coordinated support for patients. For those with complex and multiple needs as well as for difficult-to-engage clients, the continuity of care and high level of coordination of multi-modal interventions across mental health care, general health care, and social services that is provided by integrated systems may be important. Integrated systems may also facilitate the establishment of a stronger and longer lasting therapeutic relationship between clinicians and patients; and the impact of the quality of therapeutic relationship on outcomes of severe mental disorders has been well documented.

In the United Kingdom, the organization of mental health care is traditionally based on an integrated system. However, in the course of the initiative “New ways of working”, led by the Royal College of Psychiatrists and the National Institute for Mental Health, some mental health Trusts piloted a functional model. Therefore in some areas consultant psychiatrists are no longer responsible for patients across the full range of treatment settings but are only working in inpatient or outpatient settings.

These changes have led to different reactions characterized either by enthusiasm or by criticism and concerns, but no sound evidence is available on

how these changes have affected clinical practice and patient outcomes.

How COFI will provide this evidence?

COFI will compare integrated and functional systems in order to establish which of them is more effective, cost-effective, and guarantees a better experience of care to patients.

The study will involve the assessment of more than 5000 patients. The comparison between integrated and functional systems will consider clinical outcomes as well as patients' quality of life, health and social needs, safety, and cost-effectiveness of care. The experience of receiving and providing care within the two different systems will be explored also via in-depth interviews with patients and clinicians. Each outcome will be investigated in different subgroups – defined by diagnosis, age, gender, socio-economic and migrant status, and presence of physical disorders in comorbidity – of patients with different expected needs.

In each of the five countries in which COFI will be carried out (Belgium, Germany, Italy, Poland, and the United Kingdom), there are some areas in which mental health care is organized in an integrated system and others which use a functional system. This is important, as it will enable the study to carry out comparisons of the two systems that are not influenced by specific national contexts, thus providing results that will be both generalizable to other countries while identifying the factors that influence quality of care and outcomes at national levels.

COFI will provide, for the first time, systematic research evidence generated across several European countries on how best to organise mental health and inform future policies on the organization of services in the UK and across Europe. COFI results will help tailor services to the needs of specific populations (e.g. older patients, patients with different diagnoses) and maximise satisfaction of patients with received care.

The results will be used to develop guidelines for mental health service organization based on findings in order to facilitate the translation of research evidence into mental health policies and made available through scientific papers, popular media, new technologies, and workshops involving policymakers, user/carer organisations and mental health professionals.

Recent Publications

Notification of the following publications has been received since circulation of the last newsletter. *Don't be shy!!* Please send copies of papers or reference details to the Research Office (ResearchOffice@eastlondon.nhs.uk) so they can be included in this list and made available to interested staff.

■ Ajdukovic D, Ajdukovic D, Bogic M, Franciskovic T, Galeazzi GM, Kucukalic A, Lecic-Tosevski D, Schutzwahl M & Priebe S (2013) *Recovery from posttraumatic stress symptoms: a qualitative study of attributions in survivors of war*, **PLoS One** 8(8):e70579.

■ Bhui K (2013) *Mental health and violent radicalization*, **Ment Health Today** 24-26.

■ Bourke JH, Johnson AL, Sharpe M, Chalder T & White PD (2013) *Pain in chronic fatigue syndrome: response to rehabilitative treatments in the PACE trial*, **Psychol Med** 1-8.

■ Bui L, Farrington DP, Ueda M & Hill KG (2013) *Prevalence and Risk Factors for Self-Reported Violence of Osaka and Seattle Male Youths*, **Int J Offender Ther Comp Criminol** [Epub ahead of print].

■ Carr C, Odell-Miller H, Priebe S (2013) *A Systematic Review of Music Therapy Practice and Outcomes with Acute Adult Psychiatric In-Patients*, **PLoS ONE** 8(8): e70252, doi:10.1371/journal.pone.0070252.

■ Caruso R, Grassi L, Biancosino B, Marmai L, Bonatti L, Moscara M, Rigatelli M, Carr C, Priebe S (2013) *Exploration of experiences in therapeutic groups for patients with severe mental illness:*

development of the Ferrara group experiences scale (FE-GES), **BMC Psychiatry** 13(1):242, doi:10.1186/1471-244X-13-242.

■ Choudhury Y, Bremner SA, Ali A, Eldridge S, Griffiths CJ, Hussain I, Parsons S, Rahman A & Underwood M (2013) *Prevalence and impact of chronic widespread pain in the Bangladeshi and White populations of Tower Hamlets East London*, **Clin Rheumatol** 32(9):1375-1382.

Continued on page 8

Recent Publications Continued

Continued from page 7

■ Coid JW, Ullrich S & Kallis C (2013) *Predicting future violence among individuals with psychopathy*, **Br J Psychiatry** [Epub ahead of print].

■ Coid JW, Ullrich S, Keers R, Bebbington P, Destavola BL, Kallis C, Yang M, Reiss D, Jenkins R & Donnelly P (2013) *Gang membership violence and psychiatric morbidity*, **Am J Psychiatry** 170(9):985-993.

■ Curtis D (2013) *High Prevalence and Low Fecundity of Mental Disorders May Reflect Recessive Effects*, **JAMA Psychiatry** 70(10):1115.

■ Das-Munshi J, Clark C, Dewey ME, Leavey G, Stansfeld SA & Prince MJ (2013) *Does childhood adversity account for poorer mental and physical health in second-generation Irish people living in Britain? Birth cohort study from Britain (NCDS)*, **BMJ Open** 3(3).

■ Dein S & Bhui K S (2013) *At the crossroads of anthropology and epidemiology: Current research in cultural psychiatry in the UK*, **Transcult Psychiatry** [Epub ahead of print].

■ Fagg JH, Curtis SE, Cummins S, Stansfeld SA & Quesnel-Vallee A (2013) *Neighbourhood deprivation and adolescent self-esteem: Exploration of the 'socio-economic equalisation in youth' hypothesis in Britain and Canada*, **Soc Sci Med** 91:168-177.

■ Floud S, Blangiardo M, Clark C, de HK, Babich W, Houthuijs D, Swart W, Pershagen G, Katsouyanni K, Velonakis M, Vigna-Taglianti F, Cadum E & Hansell AL (2013) *Exposure to aircraft and road traffic noise and associations with heart disease and stroke in six European countries: a cross-sectional study*, **Environ Health** 12(1):89.

■ Freestone M, Howard R, Coid J & Ullrich S (2013) *Adult antisocial syndrome co-morbid with borderline personality disorder is associated with severe conduct disorder substance dependence and violent antisociality*, **Personality and Mental Health** 7:11-21.

■ González R, Gudjonsson G, Wells J & Young S (2013) *Examination of the role of emotional distress and ADHD with type of offending recidivism and behavioural disturbances among adult prisoners*, **Journal of Attention Disorders** [Epub ahead of print].

■ González RA, Kallis C, Coid JW (2013) *Adult attention deficit hyperactivity disorder and violence in the population of England: does comorbidity matter?* **PLoS One** 8(9):e75575.

■ Goodwin L, Bourke JH, Forbes H, Hotopf M, Hull L, Jones N, Rona RJ, Wessely S & Fear NT (2013) *Irritable bowel syndrome in the UK military after deployment to Iraq: what are the risk factors?* **Soc Psychiatr Psychiatr Epidemiol** 48(11):1755-1765.

■ Griva K, Mooppil N, Krishnan DSP, McBain H & Newman SP (2013) *Short and long-term outcomes of the hemodialysis self-management intervention randomised trial (hed-smart) - a practical low intensity intervention to improve adherence and clinical markers*, **Nephrology Dialysis & Transplantation** 28(suppl 1):i472-i486.

■ Howes C, Purver M, McCabe R (2013) *Using Conversation Topics for Predicting Therapy Outcomes in Schizophrenia*, **Biomedical Informatics Insights** Suppl 1:39-50.

■ Jankovic J, Bremner S, Bogic M, Lecic-Tosevski D, Ajdukovic D, Franciskovic T, Galeazzi GM, Kucukalic A, Morina N, Popovski M, Schutzwahl M & Priebe S (2013) *Trauma and suicidality in war affected communities*, **Eur Psychiatry** 28(8):514-520.

■ Kalra G, Bhui K & Bhugra D (2013) *Does Guru Granth Sahib describe depression?* **Indian J Psychiatry** 55(Suppl 2):S195-S200.

■ Keers R, Ullrich S, DeStavola B, Coid JW (2013) *Association of Violence with Emergence of Persecutory Delusions in Untreated Schizophrenia*, **Am J Psychiatry** doi:10.1176/appi.ajp.2013.13010134.

■ Kingma E, Rosmalen JGM, White PD, Stansfeld SA, Clark C (2013) *The prospective association between childhood cognitive ability and somatic symptoms and syndromes in adulthood: the 1958 British birth cohort*, **J Epidemiology & Community Health** doi:10.1136/jech-2013-202850.

■ Lee SH, Ripke S, Neale BM, Faraone SV, Purcell SM, Perlis RH, Mowry BJ, Thapar A, Goddard ME, Witte JS et al (2013) *Genetic*

relationship between five psychiatric disorders estimated from genome-wide SNPs, **Nat Genet** 45(9):984-994.

■ Macinnes D, Kinane C, Beer D, Parrott J, Craig T, Eldridge S, Marsh I, Kotrofil J & Priebe S (2013) *Study to assess the effect of a structured communication approach on quality of life in secure mental health settings (Comqol): study protocol for a pilot cluster randomized trial*, **Trials** 14(1):257.

■ McCabe R, Healey PG, Priebe S, Lavelle M, Dodwell D, Laugharne R, Snell A & Bremner S (2013) *Shared understanding in psychiatrist-patient communication: Association with treatment adherence in schizophrenia*, **Patient Educ Couns** 93(1):73-79.

■ Milsom SA, Freestone M, Duller R, Bouman M & Taylor C (2013) *Factor structure of the Essen Climate Evaluation Schema measure of social climate in a UK medium-security setting*, **Crim Behav Ment Health** [Epub ahead of print].

■ Minoudis P, Craissati J, Shaw J, McMurrin M, Freestone M, Chuan SJ & Leonard A (2013) *An evaluation of case formulation training and consultation with probation officers*, **Crim Behav Ment Health** 23(4):252-262.

■ Mulligan K, Kassoumeri L, Etheridge A, Moncrieffe H, Wedderburn LR & Newman S (2013) *Mothers' reports of the difficulties that their children experience in taking methotrexate for Juvenile Idiopathic Arthritis and how these impact on quality of life*, **Pediatric Rheumatology** 11:23.



■ Mundt AP, Alvarado R, Fritsch R, Poblete C, Villagra C, Kastner S & Priebe S (2013) *Prevalence rates of mental disorders in andomi prisons*, **PLoS One** 8(7):e69109.

■ Nawka A, Kalisova L, Raboch J, Giacco D, Cihal L, Onchev G, Karastergiou A, Solomon S, Fiorillo A, Del VV, Dembinskas A, Kiejna A, Nawka P, Torres-Gonzales F, Priebe S, Kjellin L & Kallert TW (2013) *Gender differences in coerced patients with schizophrenia*, **BMC Psychiatry** 13(1):257.

■ Pavlickova H, Turnbull OH & Bentall RP (2013) *Discrepancies between explicit and implicit self-esteem and their relationship to symptoms of depression and mania*, **Psychol Psychother** [Epub ahead of print].

■ Pavlickova H, Varese F, Smith A, Myin-Germeys I, Turnbull OH, Emsley R & Bentall RP (2013) *The dynamics of mood and coping in bipolar disorder: longitudinal investigations of the inter-relationship between affect self-esteem and response styles*, **PLoS One** 8(4):e62514.

■ Pavlickova H, Varese F, Turnbull O, Scott J, Morriss R, Kinderman P, Paykel E & Bentall RP (2013) *Symptom-specific self-referential cognitive processes in bipolar disorder: a longitudinal analysis*, **Psychol Med** 43(9):1895-1907.

■ Power RA, Cohen-Woods S, Ng MY, Butler AW, Craddock N, Korszun A, Jones L, Jones I, Gill M, Rice JP et al (2013) *Genome-wide association analysis accounting for environmental factors through propensity-score matching: application to stressful life events in major depressive disorder*, **Am J Med Genet B Neuropsychiatr Genet** 162B(6):521-529.

■ Power RA, Lecky-Thompson L, Fisher HL, Cohen-Woods S, Hosang GM, Uher R, Powell-Smith G, Keers R, Tropeano M, Korszun A et al (2013) *The interaction between child maltreatment adult stressful life events and the 5-HTTLPR in major depression*, **J Psychiatr Res** 47(8):1032-1035.

■ Power RA, Wingenbach T, Cohen-Woods S, Uher R, Ng MY, Butler AW, Ising M, Craddock N, Owen MJ, Korszun A et al (2013)

Estimating the heritability of reporting stressful life events captured by common genetic variants, **Psychol Med** 43(9):1965-1971.

■ Priebe S, Gavrilovic J, Bremner S, Ajdukovic D, Franciskovic T, Neri G, Kucukalic A, Lecic-Tosevski D, Morina N, Popovski M, Schutzwahl M, Bogic M & Matanov A (2013) *Course of post-traumatic stress disorder following war in the Balkans: 1-year follow-up study*, **Psychol Med** 43(9):1837-1847.

■ Priebe S, Yeeles K, Bremner S, Lauber C, Eldridge S, Ashby D, David AS, O'Connell N, Forrest A & Burns T (2013) *Effectiveness of financial incentives to improve adherence to maintenance treatment with antipsychotics: cluster randomised controlled trial*, **BMJ** 347:f5847.

■ Reininghaus U, Priebe S & Bentall RP (2013) *Testing the psychopathology of psychosis: evidence for a general psychosis dimension*, **Schizophr Bull** 39(4):884-895.

■ Ripke S, Wray NR, Lewis CM, Hamilton SP, Weissman MM, Breen G, Byrne EM, Blackwood DH, Boomsma DI, Cichon S et al (2013) *A mega-analysis of genome-wide association studies for major depressive disorder*, **Mol Psychiatry** 18(4):497-511.

■ Rousseau C, Jamil U, Bhui K & Boudjarane M (2013) *Consequences of 9/11 and the war on terror on children's and young adult's mental health: A systematic review of the past 10 years*, **Clin Child Psychol Psychiatry** [Epub ahead of print].

■ Rucker JJ, Breen G, Pinto D, Pedrosa I, Lewis CM, Cohen-Woods S, Uher R, Schosser A, Rivera M, Aitchison KJ, Craddock N et al (2013) *Genome-wide association analysis of copy number variation in recurrent depressive disorder*, **Mol Psychiatry** 18(2):183-189.

■ Schosser A, Butler AW, Uher R, Ng MY, Cohen-Woods S, Craddock N, Owen MJ, Korszun A, Gill M, Rice J, Hauser J, Henigsberg N, Maier W, Mors O, Placentino A, Rietschel M, Souery D, Preisig M, Craig IW, Farmer AE, Lewis CM & McGuffin P (2013) *Genome-wide association study of co-occurring anxiety in major depression*, **World J Biol Psychiatry**.

■ Sinha S & Warfa N (2013) *Treatment of Eating Disorders among Ethnic Minorities in Western Settings: a Systematic Review*, **Psychiatr Danub** 25(Suppl 2):295-299.

■ Stansfeld S (2013) *Airport noise and cardiovascular disease*, **BMJ** 347:f5752.

■ Syed Sheriff RJ, Bass N, Hughes P, Ade-Ogunlade P, Ismail A, Whitwell S & Jenkins R (2013) *Use of interactive teaching techniques to introduce mental health training to medical schools in a resource poor setting*, **African Journal of Psychiatry** 16:256-263.

■ Ullrich S, Keers R & Coid JW (2013) *Delusions Anger and Serious Violence: New Findings From the MacArthur Violence Risk Assessment Study*, **Schizophr Bull** [Epub ahead of print].

■ Valenti E, Giacco D, Katsakou C & Priebe S (2013) *Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients*, **J Med Ethics**.

■ White PD, Goldsmith K, Johnson AL, Chalder T & Sharpe M (2013) *Letter to the Editor: Response to correspondence concerning 'Recovery from chronic fatigue syndrome after treatments in the PACE trial'*, **Psychol Med** 43(8):1791-1792.

■ Wickwar S, Buerkle K, McBain H, Kassoumeri L, Ciciriello S, Osborne R, Wedderburn L & Newman S (2013) *Adaptation of the methotrexate in rheumatoid arthritis knowledge questionnaire (MRAK) for use with parents of children with juvenile idiopathic arthritis (JIA)*, **Paediatric Rheumatology** 11(27).

■ Xenitidis K, Campbell C, Das-Munshi J, Becares L, Boydell JE, Dewey ME, Morgan C, Stansfeld SA & Prince MJ (2013) *Authors' reply*, **Br J Psychiatry** 202:237-238.

■ Yang M, Wong SC & Coid JW (2013) *Violence mental health and violence risk factors among women in the general population: an0020epidemiology study based on two national household surveys in the UK*, **BMC Public Health** 13(1):1020.

■ Yiend J, Freestone M, Vazquez-Montes M, Holland J & Burns T (2013) *The clinical profile of high-risk mentally disordered offenders*, **Soc Psychiatry Psychiatr Epidemiol** 48(7):1169-1176.